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Author/s:
Biddulph, S

Title:
Public Trust and Social Order : Resolving Medical Disputes in China [in Japanese]

Date:
2016

Citation:
Biddulph, S. (2016). Public Trust and Social Order : Resolving Medical Disputes in China [in Japanese]. Kumamoto Law Review, 137, pp.71-83

Persistent Link:
https://hdl.handle.net/11343/252819

This is an accepted version of this article published in:
(2016) 137 *Kumamoto Law Review*, 71-83

Public Trust and Social Order: Resolving Grievances in China

Sarah Biddulph*

Introduction

As with any set of dispute resolution processes in any country, a core problem is how to reach a final resolution to grievances and claims. To be acceptable to the parties involved, grievances need to be addressed in a manner that is timely and perceived to be fair. This difficulty is particularly acute in China, where popular levels of trust in government and judicial decision-making are low. Recently much attention has focused on the high levels of petitioning and socially disruptive protest in many areas ranging from grievances about labour, to land, housing, environmental pollution and medical treatment. In part, reducing the level of popular grievance depends upon governance and policy reforms in these areas. But in part as well, the level of disputing and the difficulty of reaching an acceptable outcome in particular cases is exacerbated by the lack of popular legitimacy of formal institutionalised mechanisms of dispute resolution such as litigation, arbitration, and weaknesses in alternative dispute resolution mechanisms such as mediation. What features of the legal system and the participants, both citizens with grievances and state agents, are at play in producing this problem?

The paper first sets out the proposition explored in the remainder of the paper. That is: that an evaluation of problems in resolving disputes needs to take into account a number of important contextual factors that extend beyond an examination of the completeness and appropriateness of legal rules and the efficacy of legal procedures. The contextual factors examined here are the interrelated issues of lack of public trust and the role of social stability maintenance policies in shaping state responses to grievances.

The paper then develops these ideas through a discussion of the resolution of medical disputes; primarily claims of negligent medical treatment in hospitals.[1] Medical disputes have become intractable because of the convergence of several related factors. One is popular anxiety and anger because state disinvestment in the health care system in the 1980s deprived many of health care services or increased the difficulty in obtaining medical treatment, increased costs in hospital treatment resulting from expensive tests and treatments and strained doctor patient relationships. Another is difficulty in obtaining timely and fair resolution to grievances about medical treatment. Disputes have rapidly become more contentious (and so are readily perceived by the authorities as a problem of social order) and more difficult finally to resolve because of a lack of public trust in both hospitals and in dispute resolution mechanisms.

The paper briefly sketches the policies and practices that have given rise to such public mistrust of hospitals and exacerbated conflict between hospitals and patients. It then examines the dispute resolution mechanisms employed to resolve medical disputes: mediation, medical arbitration and litigation, and the interaction between them. Finally it considers the reforms made to improve the

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* This research was supported by a grant from the Australian Research Council FT130100412.
[1] This paper focuses on disputes involving hospitals as, notwithstanding reforms initiated in the 2000s they remain a major provider of primary health care and are closely associated with government.

ways in which dispute resolution mechanisms work, both separately and together. These reforms, discussed at the end of the paper, have had their as aim improving the legitimacy and so the acceptability and finality of dispute resolution in relation to cost, timeliness, impartiality of expert evaluations of causes, responsibility for and the extent of harm, fairness of trials and adequacy of compensation. Throughout, it considers the influence of social stability maintenance policies in responding to disruptive protest behaviour.

Contextual factors- public trust and social stability

Ethan Michelson's research on grievances and the ways people seek to pursue them in rural China makes the very important point that contextual factors are important in determining both the level of grievance and the ways in which people go about seeking redress for these grievances. In his research, Michelson points to the very high level of distrust of local officials in parts of Henan province; where many people starved as a result of local maladministration in the Great Leap Forward famine, suffered terribly in 1975 floods and then again from HIV/ AIDS as a result of the blood collection scandal, as a way of explaining both the high level of reported grievances and the high level of recourse to formal legal channels to address those grievances (as opposed to 'lumping' it or resolving disputes through discussions between the parties) (Michelson 2007) 471. His research also found that disputes over different subject matters are addressed differently, with personal injury cases more likely than other types of grievance to be taken to formal legal channels for resolution (Michelson 2007).

His research suggests that both the context in which disputes arise and the nature of the dispute itself (relating to personal health) are important factors in understanding both the number of grievances and the ways in which people pursue them. These insights suggest that the processes of identifying a complaint as a grievance and then the decisions made to pursue redress are iterative and are shaped in part at least by state responses to complaints. It is a process that involves interactions between citizens and state agents, possibly over an extended period. This insight suggests we should focus our attention on both the aggrieved parties and those empowered to deal with disputes, the priorities and incentives to act in certain ways of both citizens and state agents. What are the expectations of the parties to a dispute and their views of what can be gained in pursuing grievances in a certain way? What are the incentives and objectives of state agents who intervene in and who seek either to dissipate or resolve these grievances? The shallow roots of the Chinese legal system in the popular imagination have led to judgments of the system being made based on the acceptability of the outcome – a type of performance legitimacy. How does the Party-state move beyond this to strengthen the legitimacy of the dispute resolution mechanisms themselves (rather than the current focus on the outcome)? Is it in fact a priority of the Party-state to strengthen the legitimacy of dispute resolution mechanisms, or is it just one of several competing priorities?

One possibly competing priority that we need to consider is stability maintenance. Research on the impact of stability maintenance on dispute resolution suggests that it has had a negative impact on institutional mechanisms for grievance settlement. In the area of labour disputes for example, (Lee and Zhang 2013) have noted that local authorities are mobilised to fragment and dissipate labour related protests through negotiation, bargaining and paying off protesters (Su and He 2010), (Lee and Zhang 2013). This form of bargaining often bypasses legal processes and legal standards. As

Chen states: '[T]he quest for stability, in a populist climate that does not value institutional boundaries and formal procedures, often spurs government functionaries to go way beyond their nominal roles in order to pacify protesters' (Chen 2013), 62.

This willingness to use extra-legal channels to dissipate protests has been seen to undermine the authority of law and the exercise of legally authorised power in the eyes of both the workers and government and Party agencies (Lee and Zhang 2013), (Cooney, Biddulph, and Zhu 2013). Instrumentalist approaches to legality and dispute resolution have been identified as both encouraging disruptive behaviour and creating contempt for legal rules and forms (Chen 2013), 63, (Lee and Zhang 2013), suggesting that stability maintenance policies might themselves be implicated in instability.

Problems of medical treatment and public trust in the reform era

In the 1980s the pre-existing socialized system of health care was dismantled (Blumenthal and Hsiao 2005).The central government withdrew much of its funding from hospitals and clinics and instead devolved responsibility for funding to provincial and local authorities, who in turn, devolved responsibility for management and funding of hospitals to the hospitals themselves. Hospitals began to increase their revenue raising activities including ordering expensive tests, medications and procedures (Blumenthal and Hsiao 2005). Even though these policies were rolled back, and from 2003 government funding of hospitals and medical insurance schemes was increased, neither the Chinese Communist Party ('Party') nor the government has been able to prevent hospitals from continuing to levy high imposts on patients, or to reduce the high levels of corruption by both doctors and hospitals (Tam 2011), 266.

The increase in the cost of health care led to large scale anxiety in the population who faced the prospect of the whole family being impoverished if one member of the family fell seriously ill. It also encouraged development of a consumer mentality in patient's relationships with doctors, with increased expectations of attentive and courteous treatment and a positive outcome. Failure to meet these expectations has fuelled a dramatic increase in grievances and protests about medical treatment. Many lay blame on both the entrenched corruption in the healthcare system, with continuing problems of poor access to good quality and affordable health care, and to failures in the mechanisms for resolution of medical disputes. Some explain difficulties in reaching a final solution to medical disputes through officially sanctioned channels as a vicious cycle, which is fuelled by mistrust and which has undermined the legitimacy of both the health care system and the legal system for resolution of grievances.[2] Mistrust has in turn contributed to the rise in complaints about treatment outcomes, extra-legal and sometimes violent forms of protest and violent attacks on doctors and medical staff.

Many manage to obtain compensation from the hospitals by disrupting their ordinary functioning. Many protests outside hospitals result in damage to and even closure of hospital operations, at great economic cost. This form of protest was even given its own name; Y*inao* (医闹), causing havoc in hospitals. Perversely, success in obtaining compensation through disruptive conduct reinforces the lack of trust in both medical and legal institutions and encourages more to behave disruptively. A

[2] (Tang et al. 2008) at 1493, 1496 describe three elements to the vicious cycle: market failure and insufficient government management or investment in health care, inequities in social determinants of health and public perceptions of unfairness of the system coupled with erosion of public trust in the health care system.

2006 survey of 350 hospitals undertaken by the Chinese Medical Association reported that in 2004; 89.58%, in 2005; 93.75% and in 2006; 97.92% of hospitals reported being subject to *Yinao* (Fan 2011), 56). The Ministry of Health (since March 2013 the National Health and Family Planning Commission) released statistics indicating that in 2010 there were 17,243 incidents of *Yinao* in hospitals, an increase of 7,000 from 2006 (People's Daily Online 4 May 2012). Some feared that the increase in large scale, violent protests outside hospitals was increasingly being instigated for profit by families, professional trouble-makers, or even organised crime (People's Daily Online 4 May 2012).

The volume of medical related litigation against hospitals has also increased dramatically. Violence in and around courts in the course of litigation is also common. In his study of medical negligence litigation (Liebman 2013) notes the common occurrence of violence in the localities he surveyed. He concludes that the 'formal legal system operates in the shadow of protest and violence' (Liebman 2013), 186).

Petitioning is another means commonly used for seeking redress for grievances. Under the system of letters and visits (State Council *Regulations on Letters and Visits* 2005 信访条例) a person may either write or visit the complaints section established within all agencies of state: local government, health bureau, hospital, or courts. Many will simultaneously complain to all agencies they consider may be relevant to airing, investigating and hopefully resolving the issue. Many also complain to agencies at a higher administrative level in the hope that they will instruct the subordinate level decision-maker to resolve the problem. A large number of complaints are also made against judicial agencies, including courts. Complaints against courts are not confined to complaints against judgments with which the party is not satisfied, but may also be made during the course of the trial (Zhang 2012), (Xiong 2009).

From the mid-1980s protest arising out of dissatisfaction with medical treatment increasingly became identified as a serious threat to social order (Biddulph 2015), 136. A range of measures were progressively implemented from this time; to improve the security of hospitals, to ensure early intervention in medical disputes, to improve dispute resolution measures, and to strengthen punishment of disruptive and violent conduct (Biddulph 2015), 150-164. Finally, in 2014, the Premier, LI Keqiang and the Vice-Premier, Liu Yandong, initiated a nationwide crackdown on *Yinao* in an attempt to stem this form of disruptive protest and pursuit of grievances (Biddulph 2015), 165-168. Coupled with reforms to improve dispute resolution processes, discussed below, anecdotal reports suggest that disruptive conduct in and around hospitals have reduced.

It is against this background that an analysis of dispute resolution in medical disputes takes place.

Medical disputes: dispute resolution mechanisms

Negotiation and Mediation

By far the most popular mechanism for dispute resolution is direct negotiation between the parties or mediation (Fan 2011), 57). Estimates of between 85% (Jiang 20 October 2010) and 91% (Wang 2011) of all medical disputes are resolved through direct negotiation between the hospital and the aggrieved party. (Wang 2011) further stated that up to 2011 3.1% of disputes are resolved by

administrative processes administered by the health departments and a further 5.6% resolved through litigation (2011b).

Mediation of medical related disputes comprises a significant proportion of the work of People's Mediation Committees. These committees operate under the leadership of local justice departments. They are charged with early identification and intervention in disputes with a view to reaching a resolution and thus preventing disputes escalating into a social order problem. (Hong 2011).

Despite the large number of mediated settlements, this form of dispute resolution has proven to be unsatisfactory in a number of respects, with many negotiated and mediated agreements failing finally to resolve the dispute between the parties. Until recently, local mediation committees have lacked medical expertise. Mediation agreements also lack binding legal effect and so cannot be enforced. Claimants frequently do not trust that the hospital has revealed full information, or believe that the hospital has covered up its liability whilst seeking to minimise the amount of compensation payable. In many cases patients (and their families) come to regret the amount of compensation agreed. Especially if they have ongoing hospital costs, they will continue to pursue the hospital for further compensation. As a result, further disruptive conduct can occur in the course of negotiations or after an agreement has been reached (Wang 2011).

In many locations throughout China, local initiatives have been taken to improve the effectiveness of mediation and to forestall protests; by establishing specialist medical disputes mediation committees and instituting coordinated multi-agency approaches to dealing with medical disputes. In Shanghai for example in 2014 the *Measures on Preventing and Handling Disputes between Hospitals and Patients* were passed to establish a multi-agency, coordinated approach to dealing with medical disputes. In these measures, the justice department was made responsible for developing, managing and supervising the medical disputes mediation mechanism. Police were responsible for maintaining order in medical establishments and dealing with disruptive conduct in hospitals and mediation centres in a timely manner. The Health and Family Planning department was made responsible for establishing dispute prevention mechanisms within medical institutions and for directing disputes to specialist medical mediation committees for resolution (article 4). The Health and Family Planning and Justice departments were made responsible for establishing an expert advisory database (article 7). Local governments and their finance departments are to finance mediation offices and employees (article 8). Medical institutions were required to take out insurance (article 9). In the arrangement of roles and responsibilities, stability maintenance and dispute resolution objectives are elided. Much has been claimed for the effectiveness of these initiatives, though it might be too early to get a clear picture of how well these mechanisms function in practice.

Administrative mechanisms: the medical accident regime

Medical disputes may be resolved through formal channels either by medical arbitration (a form of administrative determination) or judicially through a claim in tort. Whilst both systems continue to exist in parallel (and in competition with each other) - the so-called dual track system - the number of cases resolved through medical arbitration has decreased dramatically since passage of the *Tort Liability Law*.

The administrative mechanism for determining liability for injury to patients administered is set out in the 2002 *Regulations on Handling Medical Accidents*. The basis for liability is the determination that there has been a 'medical accident'. The scheme limits access to compensation in respect of adverse treatment outcomes by: limiting the types of conduct that constitute a 'medical accident', controlling the ways a determination of liability is reached and limiting the amount of compensation payable. Hospitals have thus traditionally favoured medical arbitration, both because the categories of liability are narrower than in tort law, and because the amounts of compensation payable are generally lower.

Appraisal of medical accident is carried out by medical professionals drawn from a medical review board (Medical accident specialist authentication committee 医疗事故技术鉴定委员会) drawn from members of the local medical association and administered by the local health department (which also has responsibility for managing hospitals). Members of the medical review board are nominated by the health department (the specific division of which is also responsible for handling letters and visits work and investigation) and appointed by the local government (Xiao 2010) 426. The review board determines whether a medical accident has occurred (and so the liability of the hospital for the harm), and if so, the extent of compensation. But anonymity of the authors of the report and the general way in which the report's findings are written make it difficult for both the patient and the court (on appeal from the arbitration) to evaluate the reliability of the report's conclusions. Popular and judicial perceptions that these reports lack impartiality and are largely protective of hospitals, are borne out by the low proportion of cases where fault is found.[3]

Judicial dispute resolution: Tort Liability Law 2010

An aggrieved party may also pursue a claim of compensation for medical negligence in tort under the terms of the *Tort Liability Law*. As the range of compensable conduct under the *Tort Liability Law* is broader and the amount of compensation that may be awarded is greater, aggrieved parties strongly prefer litigation over medical arbitration (Xiao 2010) 427; (Xi and Yang 2011), 70; (Wang and Oliphant 2012); (Liebman 2013). There is a popular perception as well that a claim has more chance of success in civil litigation than under the medical arbitration process. As a result, the system of medical arbitration, whilst it still exists, has been largely displaced by civil litigation for medical negligence. Despite the advantages of litigation over medical arbitration, claimants continue to face a range of difficulties in pursuing claims in court of: delay, cost of the litigation and difficulty in obtaining and adducing evidence to prove negligence in medical treatment and a causal link to the harm suffered.

To address the evidentiary questions about the medical treatment and causal relationship between treatment and harm, parties can apply to the court for judicial authentication of medical harm (医疗损害鉴定) (to be conducted by an appraiser agreed between the parties, or failing agreement, appointed by the court *Civil Procedure Law* (as amended in 2012) article 76), or the court of its own volition can organise for judicial authentication to be conducted. The judicial authentication report

[3] (Xiao 2014) p 177 reporting the results of a survey of judges conducted in Guangdong in 2013. (Xi and Yang 2011) 70-71 cite survey findings that found 7.8% of medical review board cases in Beijing between 2003 and 2007 held that a medical accident had occurred. This compares to 62% of cases from the same period where negligence was held to have occurred in the parallel fault-based tortious liability regime.

provides expert evidence assessing the quality of medical treatment and its relationship to the medical harm caused to the patient.[4]

Accessing an expert and impartial assessment of the quality of the medical treatment received, and its causal relationship to the harm suffered, is a key to obtaining a timely and fair judgment in often complex and emotional cases. However, problems remain. One is whether such a process is perceived to be sufficiently expert and impartial for the parties to accept the report's findings. This question relates to the degree of technical expertise of the appraiser, their honesty and reliability and their impartiality. It also relates to the capacity to require the report's author to appear in court to respond to questions about matters contained in the report. Another question is whether the judicial authentication process shortens the time required to reach a final determination.

To regularise the provision of expert appraisals of technical, specialist and medical questions in medical negligence cases before the court, the NPC Standing Committee authorised establishment and registration by the justice departments of judicial authentication institutions.[5] Institutions able to demonstrate requisite expertise and experience in a given field may then obtain registration. A 2013 survey of judges in Guangdong showed that judges hold doubts about the reliability of judicial authentication reports, fearing that the quality of these reports may be prejudiced by either financial inducements, or lack of technical competence. It also found that they have even less trust in the impartiality of medical review committees.[6] Courts retain discretion about whether to accept the findings of the judicial authentication report and then whether to base their judgment on the report's findings. In practice, judges are inclined to accept the report's conclusions because the appraisers are independent and experts and because judges lack independent expertise to diverge from the findings of these appraisal reports. (Xiao 2014).

An important element in improving the parties and court's trust in the reliability of an authentication report, and so acceptability of the judgment, is the capacity to require the person conducting the judicial authentication to appear in court to answer questions about the report. Whilst judicial appraisers have long been required to appear in court if either of the parties or the court requires,[7] because of legal exceptions and unwillingness they seldom appear. One estimate is that that they appear in less than 5% of cases. (Kou, Guo, and Song 2014) 33. A 2012 amendment to the *Civil Procedure Law* (article 78) requires that the author of a judicial authentication report appear in court where there is a difference of opinion about the judicial authentication report, or where the court

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[4] Civil Procedure Law article 76 (as amended in 2012). After passage of the PRC *Tort Liability Law* (中华人民共和国侵权责任法)the Supreme People's Court issued the *Notice on Several Questions on application of the 'PRC Tort Liability Law'* 2010 (关于适用〈中华人民共和国侵权责任法〉若干问题的通知) which provided at article 3 that in hearing a case of medical negligence a party could request, or the court could itself arrange for a (医疗损害鉴定)medical harm authentication to be carried out in accordance with the provisions of the 2005 NPC Standing Committee *Decision of the Standing Committee of the National People's Congress on the Administration of Judicial Authentication* 2005 (全国人民代表大会常务委员会关于司法鉴定管理问题的决定)and the *Provisions on the Administration of Judicial Authentication made upon Entrustment of the People's Courts* (人民法院对外委托司法鉴定管理规定) 27 March 2002

[5] *Decision of the Standing Committee of the National People's Congress on the Administration of Judicial Authentication* 2002 全国人民代表大会常务委员会关于司法鉴定管理问题的决定

[6] (Xiao 2014) p 177 reporting the results of a survey of judges conducted in Guangdong in 2013

[7] (Supreme People's Court *Several Regulations on Evidence in Civil Litigation* 最高人民法院关于民事诉讼证据的若干规定 2002 article 59, *Decision of the Standing Committee of the National People's Congress on the Administration of Judicial Authentication* 2005 article 11)

orders. If they refuse, the judicial authentication report cannot be used as evidence and the party paying the appraisal fee can obtain a refund.

The second issue is that of delay in reaching a judgment. Tort claims based on medical negligence remain characterised by the complexity and technicality of facts and interpretation in contention. The 2007 Ministry of Justice *General Principles of Procedure in Judicial Authentication*（司法鉴定程序通则）article 26 requires that the judicial authentication organ complete the appraisal within 30 working days of receiving written entrustment. However in practice problems; of obtaining cooperation of both parties in obtaining evidence, complexity of the evidence, in defining the scope of the appraisal, and in obtaining payment of fees can lead to delays (Kou, Guo, and Song 2014) 33. Another element of delay arises where judicial authentication reports are contested by one of the parties, where parties seek to introduce competing judicial authentication reports, or ask for repeated reports.

Hospitals in particular have been hostile to judicial authentication (particularly its displacement of the medical review board system), arguing that judicial authentication bodies do not have requisite skills to evaluate whether the treatment is negligent or that there was a causal link between the treatment and the harm. They also argue that such a system leads to delays and inconsistencies in reaching an outcome in a dispute, harms the doctor patient relationship and encourages defensive treatment practices (Xiao 2010) 428-9, (Kou, Guo, and Song 2014). Some complain that judicial over-reliance on a written judicial authentication on questions of fault and causation (authentication substituting for adjudication 以鉴代审) itself is pointed to as being the cause of a high number of appeals or petitioning against court judgments (Kou, Guo, and Song 2014) 33.

Social stability and dispute resolution

Despite the substantial legal reforms discussed above, it is also common for concern about social stability to have a substantial impact on the ways in which a court handles a case; often driven more by considerations of social stability than legal rights. This concern is manifest in a number of ways. One is the unwillingness of some local level courts to put on file initiating process in medical negligence litigation (不立案). More apparent are cases where hospitals pay compensation regardless of their legal liability and where courts make awards greater than the law would otherwise require in order to defuse protests (Liebman 2013). Liebman notes that courts often decide cases 'in the shadow of protest' and that this concern can override the strict application of law in adjudication (Liebman 2011), (Liebman 2013), 186.

Not only does concern for stability impact on the ways in which cases dealt with through formal dispute resolution channels are handled, it also encourages officials to bypass formal legal channels to resolve disputes. Where local governments are involved, dispute resolution can easily become an exercise in stability management, with protests resolved either by making *ex gratia* payments or by using repressive force. Such a focus can divert attention away from addressing the substantive dispute between the parties. A perverse effect of this focus on stability management is that many citizens are led to believe that only if they cause trouble will they have their substantive grievance addressed and obtain compensation (Hu 8 June 2012). A common saying is that only if one makes a big fuss will the problem be resolved (大闹大解决，小闹小解决，不闹不解决)(Zhang 2012). Many conclude that all of these factors combine to contribute to undermining the legitimacy of the

medical treatment regulatory regime and trust in dispute resolution processes (Jin and Yao 2011), 179-180).

Conclusion: the roles of public distrust and social stability policies

Distrust in both the medical system and the systems for resolution of disputes arising from grievances about medical treatment provides important context for an evaluation of dispute resolution mechanisms. This context goes some way to explaining the rapidly escalating levels of disputing in respect of medical treatment and the willingness of many to use a range of extra-legal, disruptive measures. A truism amongst commentators is that distrust of the legal system and formal legal modes of redress drives petitioning: (信 '访"不信 '法' (Duan and Qiao 2012), 74. An incentive for disruptive behaviour is over-responsiveness of local state agencies to these disruptive protests. This sensitivity to protest has contributed to emergence of a negative feedback loop which has seen a dramatic increase from the mid-1980s in the amount of petitioning and disruptive protest behaviour seeking to improve the complainant's bargaining position and to bring the hospital to the negotiating table.

Increasingly social order management tools have been used to deal with medical related disputes and protests. By the mid-2010s disruptive protests in grievances about medical treatment had become so commonplace, with some incidents of such violence, that central authorities launched a concerted campaign to crack down on offenders and to persuade those with grievances to pursue more regular channels of dispute resolution. Reforms made to the scope of acceptable petitioning in turn have sought to limit recourse to repeated petitioning or petitioning to higher level agencies and to stem the increase in law-related petitioning, particularly before a final judgment is issued in a case. It remains to be seen how successful this crack-down has been in the long term.

To address the causes of popular dissatisfaction it has also been necessary to institute reforms in both the provision of health care and in the ways in which disputes about health care are addressed. These have also taken place. In addition to introducing wide-ranging reforms to the system of primary healthcare and health insurance, efforts have been made to improve the quality of dispute resolution. Introduction of specialist mediation committees and coordinated multi-agency approaches to addressing grievances about medical treatment at the local level were two. The much distrusted system of medical arbitration, while not abolished, has faded from prominence and been replaced largely by medical negligence litigation. In medical negligence litigation, reforms have also been made to procedures for obtaining and providing evidence. However, problems and difficulties remain, not least of which is cost and delay in resolving medical negligence litigation.

The two track system of medical arbitration and civil litigation continues to exist. As discussed above, there are problems in each of medical arbitration and medical negligence litigation. In addition, the coexistence of two divergent processes and sets of legal rules for determining liability for harm arising from medical treatment still fails to provide clear and simple bases for making complaints, determining liability and establishing standards for compensation for harm arising out of medical treatment. In the context of an overwhelming power and information imbalance between hospitals and their doctors and patients, the lack of a straightforward and clear mechanism for making and resolving claims is one issue needing urgent attention.

This is an accepted version of this article published in:
(2016) 137 *Kumamoto Law Review*, 71-83

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